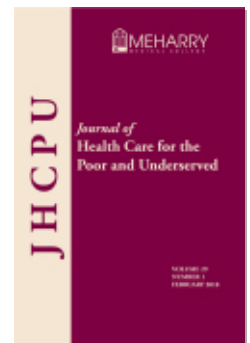




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Providing IUDs in Community Health Care Settings

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“Birth Control can Easily Take a Back Seat”: Challenges Providing IUDs in Community Health Care Settings

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Abstract: Objective. To assess community health centers' (CHCs) capacity to offer streamlined intrauterine devices (IUDs) services. **Methods.** Prior to implementing a contraceptive training project, we surveyed health care staff (N=97) from 11 CHC sites that offer IUDs onsite. Twenty interviews with clinicians explored more deeply their challenges offering IUDs in the CHC setting. **Results.** Most practices required multiple visits for IUD placement, most (66%) clinician survey respondents had placed an IUD and 19% had placed an IUD as emergency contraception. Need for screening tests, scheduling challenges, pressures to meet patient quotas, and lack of priority given to women's health hindered streamlined IUD provision. **Conclusions.** Although access to IUDs has increased, significant barriers to provision in CHC settings persist. Clinic policies may need to address a variety of system and provider-level barriers to meet the needs of patients.

Key words: Contraception, primary care, community health centers, IUDs, emergency contraception.

Community health centers (CHCs) are primary care centers whose mission is to serve uninsured, underserved, and marginalized populations. Many CHCs are also designated as federally qualified health centers (FQHCs), meaning they qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. CHCs are increasingly becoming a primary source of care for reproductive age women. Since 2000, it is estimated the number of health centers has increased by 64% and the number of patients served has more than doubled.¹ This growth is attributed to Medicaid expansions as well as increases in federal funds aimed at CHCs.¹ While CHCs are required to offer contraception as part of their scope of primary care services, the

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range of methods available varies considerably by practice setting.²⁻⁴ It is estimated that slightly over half of CHCs offer IUDs onsite.²⁻⁶

Attitudinal barriers, lack of provider training, stocking challenges, and lack of streamlined and coordinated services reduce patient access to IUDs.^{5,7} While same-day IUD placement is considered best practice as long as pregnancy can be reasonably excluded, availability of streamlined services is limited.⁸ In a recent survey of California practices offering family planning services, less than 30% of CHCs offered same-day IUD placements, compared with 95% of Planned Parenthood practices.⁹ Perceived need for STI (sexually transmitted infection) testing and scheduling and clinic flow challenges have been mentioned by that and other studies as impeding same-day IUD placement.^{9,10}

The IUD is the preferred and most effective emergency contraceptive (EC) option for patients interested in the IUD.¹¹ Emergency contraceptive pills can be used up to five days after unprotected sex, with pregnancy rates over 6%, whereas the copper IUD can be placed up to 10 days after unprotected sex with a pregnancy rate as low as 0.09%.¹² While there has been a steady increase in the proportion of women using the IUD,¹³ IUD as EC use is still infrequent.¹⁴ A recent survey of health care providers working in academic centers indicated that fewer than 5% of pediatric, internal medicine, or emergency medicine providers had ever provided the IUD as an EC option, compared with 36% of reproductive health specialty providers.¹⁵ Barriers to providing the IUD as an EC option include lack of streamlined and coordinated services.

Gaining a better understanding of IUD delivery practices as well as the challenges faced by clinicians in CHC settings to provide streamlined care is important so that we can find ways to make these options more readily available to interested patients. This paper presents the results of a secondary analysis of a larger project aimed at training clinicians and staff from CHCs in the San Francisco Bay Area (Bay Area) on IUD and implant provision. Study participants all worked in practices where the IUD is available onsite at no cost to patients. Thus, these are settings where many of the obvious barriers to IUD access have already been removed. Using a mixed methods approach—in-depth interviews and surveys of CHC providers and staff—this study sought to identify practices and challenges with streamlined IUD provision at Bay Area CHCs.

Methods

From April–June 2015, staff from the University of California, San Francisco, held six separate educational seminars and two Continuing Medical Education (CME) hands-on IUD and implant placement trainings were held. Eligible training sites offered the copper and levonorgestrel (Mirena) IUD onsite and were part of a Bay Area network of CHCs. This network comprises eight parent agencies, each with multiple service sites ranging from two to 28 sites per agency. Seven out of 13 eligible sites agreed to participate. One training seminar was held per site in all but one case, where one training was held for two sites from the same parent agency. These seven participating sites represented three parent agencies; four sites were Title X funded. Reasons for not participating included scheduling challenges, changes in leadership, and perceived lack of need for training. All clinicians and staff from each training location were invited to participate in the training. Although not explicitly

invited, interested participants from other agencies and sites within the CHC network that offered IUDs to their patients were permitted to participate.

Data for this analysis come from surveys of clinicians and staff who participated in the training and semi-structured telephone interviews with clinicians working in Bay Area CHCs, some within and some outside of the participating training sites. The services provided and populations served at the practices represented by the interview and survey respondents were typical of FQHCs/CHCs. Services provided included primary care, reproductive health care, geriatrics, and pediatrics; the patient population was mostly low-income, ranging in age from infant to aging populations. Even in the school-based health centers (SBHCs) where some of the interviewees worked, patient school grades ranged from kindergarten through high school. This study received ethical approval from the Committee on Human Research at the University of California, San Francisco.

Clinician and staff surveys. All training participants were asked to complete a survey prior to the training. Two weeks before a scheduled training, paper surveys and links to the online survey were distributed to all clinicians and staff working at the location where the training was to take place. Participants were reminded to complete the survey when registering and checking in to the training, and the day before the training. All surveys were collected before the training began. Participants received a \$20 gift card for completing the survey.

Survey items were based on prior research surveying California providers about their IUD delivery practices^{9,16,17} and included questions about the CHC practice setting and respondent's attitudes and practices around IUDs and implants, including IUD as EC. The survey was first pilot-tested among seven clinicians and staff at one neighborhood youth-serving clinic outside of the CHC training network, to test comprehension and administration procedures. Data were analyzed using Stata Version 14.¹⁸ We ran frequencies on variables related to IUD access, barriers to same-day placements, and recent changes in IUD provision. We used unadjusted mixed effects logistic regression to account for clustering by CHC workplace site to assess whether barriers to same-day provision differed by whether the respondent discusses contraception with patients.

Clinician interviews. While survey results were useful for measuring the prevalence of variables suspected or known to reduce access to IUDs, we conducted in-depth interviews with clinicians to uncover new impediments and explore the sometimes opaque nature of known barriers in order to understand how to address them well. From April–August 2015, 20 clinicians were recruited to participate in a one hour-long, in-depth semi-structured telephone interview regarding their experiences offering IUDs, IUD training needs, and barriers to IUD provision in their practices. Clinicians working in a CHC setting, who provided primary care and contraceptive services, and who served adolescent and young women were eligible to participate. We were interested in talking to providers who serve young women because of prior research demonstrating that providers are more reluctant to recommend IUDs to this population.¹⁶ In order to capture clinicians' experiences prior to and after the training, we interviewed clinicians who had and who had not participated in the training. Clinicians were recruited through an email communication announcing the educational seminar held by our group, as well as during each training event. Clinicians were telephone-interviewed by trained

interviewers (two of the study authors). Oral consent was obtained by telephone and permission to audio-record was requested prior to beginning the interview. All but one clinician granted permission to be audio-recorded. Participants received a \$50 gift card for participating in the interview.

The analytic team comprised three of the study authors. Audio-recorded interviews were transcribed verbatim. We relied on typewritten notes for two interviews: one for the clinician who refused audio-recording and the other because the audio-recording was poor. All coding was done in Dedoose.¹⁹ Two study authors independently generated a list of codes after reviewing two interviews. These authors discussed their independent list of codes and revised the code list after discussion and consensus. A third author was consulted to discuss the code list, until a final list of codes was generated. Initial interviews were recoded using this final code list, and additional interviews coded.

Results

Survey and clinician interview sample descriptions. A total of 120 clinicians and staff participated in one of our educational seminars, of whom 97 completed a baseline survey. Survey respondents represented five CHC parent agencies from 11 different Bay Area locations.

Twenty clinicians participated in the qualitative telephone interviews. Half were interviewed after participating in our educational seminar (n=10) and also completed a baseline survey because they were part of the training program. Interview respondents represented five CHC parent agencies from 12 Bay Area locations. Interviewees saw patients of all ages, with a handful serving specifically adolescent and young adult populations, or just adult populations. All interviewees reported that IUDs were available in their practice, one-quarter mentioned that they thought the IUD as EC was offered but “not often” or just “theoretically” and three-quarters were unsure or believed the IUD as EC was not provided in their practice. Survey and interview participant and practice characteristics are presented in Tables 1 and 2.

Survey results: practice characteristics. While training sites were selected because they offered IUDs onsite, some survey respondents, in particular those who did not provide contraceptive counseling, were unaware that their practice offered them (Table 2). Over half of survey respondents (56%) reported that usually more than one visit is required for IUD placement; about 60% that they would be somewhat or very comfortable recommending the IUD to nulliparous women and less than half reported they would be comfortable recommending it to women with a history of ectopic pregnancy (46%), pelvic inflammatory disease (PID) (40%), or as EC (47%); and nearly all (90%) felt “not at all” pressured to offer patients the IUD.

According to most survey respondents, in the past three years their practice has observed increases in patient interest (31% very much and 56% somewhat), provider receptivity towards IUDs (33% very much and 49% somewhat), and in the number of providers trained to place IUDs (32% very much and 46% somewhat) (Figure 1). Well over half reported that same-day IUD placements were introduced or increased (59%) and 40% reported that IUD as EC placements increased. As many as 6%–11% did not report or did not know whether IUD provision had changed in their practice (Figure 1).

Table 1.
PARTICIPANT CHARACTERISTICS

Participant Characteristics	Survey	Qualitative interviews
Total	97 (100%)	20 (100%)
Race/Ethnicity, n (%)		
Latino/a	40 (41%)	1 (5%)
White	25 (26%)	11 (55%)
Black/African American	7 (7%)	5 (25%)
Asian/Pacific Islander	17 (18%)	1 (5%)
Mixed Race/Other	8 (8%)	2 (10%)
Age, mean (standard deviation)	35 (10)	40 (9)
Gender, n (%)		
Female	86 (89%)	16 (80%)
Male	9 (9%)	2 (10%)
Transgender	2 (2%)	2 (10%)
Role at the clinic, n (%)		
Medical assistant	30 (31%)	0 (0%)
Clinician	28 (29%)	20 (100%)
Clerical/Billing/Other administrative staff	8 (8%)	0 (0%)
Community Health Worker	6 (6%)	0 (0%)
Health Educator/Counselor	2 (2%)	0 (0%)
Medical director ^a	4 (4%)	0 (0%)
Clinic manager	2 (2%)	0 (0%)
Registered Nurse	4 (4%)	0 (0%)
Other/Missing	13 (13%)	0 (0%)
Clinician		
Physician	10 (31%)	3 (15%)
Advanced Practice Clinician	19 (59%)	16 (80%)
Physician Assistant	3 (9%)	1 (5%)
In their CHC position, discusses contraception with patients, n (%)		
Yes	59 (61%)	20 (100%)
No	38 (39%)	0 (0%)
Ever placed IUD—clinicians ^b only, n (%)		
Yes	21 (66%)	11 (55%)
No	11 (34%)	9 (45%)
Ever placed IUD as EC—clinicians ^b only, n (%)		
Yes	6 (19%)	3 (15%)
No	26 (81%)	17 (85%)

^aWhile all the medical directors surveyed are also clinicians, they are listed here only as medical directors.

^bAlso includes medical directors.

Table 2.**IUD ACCESS IN PARTICIPATING CHCs ACCORDING SURVEY RESPONDENTS**

	N (%)
Total respondents	97 (100%)
IUD methods available onsite, n (%)	
Copper IUD (Paragard)	
Onsite	88 (92%)
Not onsite	0 (0%)
Don't know	8 (8%)
Hormonal IUD (Mirena)	
Onsite	91 (95%)
Not onsite	0 (0%)
Don't know	5 (5%)
Hormonal IUD (Skyla)	
Onsite	26 (31%)
Not onsite	32 (39%)
Don't know	25 (30%)
Usual number of visits for IUD placement, n (%)	
Same Day	24 (25%)
2 or more visits	54 (56%)
Don't know/Not applicable	19 (20%)
Proportion of patients who get the IUD the same day requested, n (%)	
Many/Most/All	16 (17%)
Less than half/half	14 (15%)
Very Few/None	41 (43%)
Don't know/Not Applicable	24 (25%)
Among respondents who provide contraceptive counseling as part of their work:	59 (100%)
Very or somewhat comfortable recommending the IUD, n (%)	
To nulliparous women	42 (75%)
To women with history of pelvic inflammatory disease	27 (48%)
To women with history of ectopic pregnancy	31 (55%)
As emergency contraception	32 (62%)
Number of reproductive age females seen last month, mean (SD)	71 (76)
No. of patients with whom discussed contraception last month, mean (SD)	42 (72)
Ever felt pressured to offer patients the IUD, n (%)	
Not at all	46 (90%)
Very little	3 (6%)
Somewhat	2 (4%)
To a great extent	0 (0%)

Notes:

IUD= Intrauterine Devices

CHCs=Community Health Centers

SD=Standard deviation.

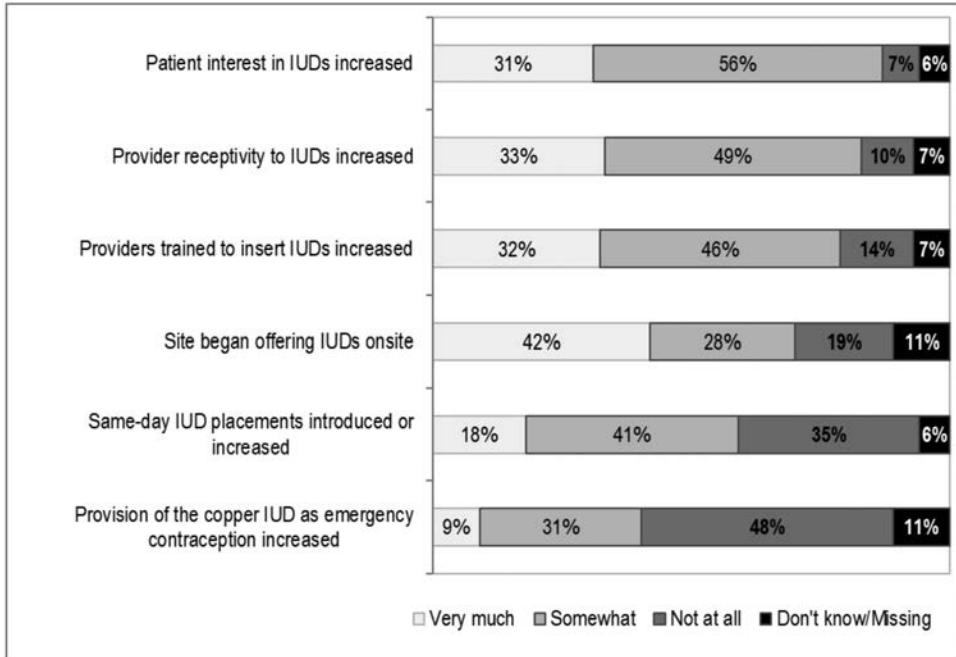


Figure 1. Proportion of respondents reporting changes in IUD provision in their practice in the last 3 years (N=97).
IUD= Intrauterine Devices

Survey results: Barriers to IUD provision. The most frequent reasons given for multiple visits for IUD placement included pregnancy test required (37%), insufficient time within one visit (31%), the need to wait for pregnancy test results (30%), and chlamydia/gonorrhea (CT/GC) test required (24%) (Table 3). The barriers to same-day IUD placement differed significantly ($p < .05$) by whether the respondent discussed contraception with patients (Table 3). Clinician interviews indicated that same-day IUD placements were not commonplace or difficult; they offered further reflections including their interpretations of why and about how difficulties are managed, which are described below.

Interview results. Contraception takes a back seat in CHCs. The perceived lack of support and low priority given to contraception by the administrations in respondents' workplace settings was felt to compromise providers' ability to offer contraception to their patients. As one provider explains "birth control can easily take a backseat to what are perceived as more . . . urgent health needs." Another describes how "There's not a lot of . . . emphasis placed on women's health, and that's just the way it is at that [community health] clinic, and all the clinics I work in." Another provider describes her frustration, "Our clinic, it's really primary care focused . . . trying to get a word in edgewise about women's health care has always been difficult. We have provider meetings that are focused on primary care." The lack of focus on women's health as well as the intense pressures to serve a high volume of patients further exasperated providers

Table 3.

**REASONS GIVEN FORM MULTIPLE VISITS FOR IUD
PLACEMENT BY WHETHER RESPONDENT DISCUSSES
CONTRACEPTION WITH PATIENTS (N=85-91)**

Reasons given (Always/usually) for multiple visits needed	Total	Discusses contraception with patients	
		Yes	No
Pregnancy test required	33 (37%)	14 (25%)	19 (56%)*
Insufficient time within one visit	27 (31%)	22 (41%)	5 (15%)*
Must wait for pregnancy test results	26 (30%)	12 (22%)	14 (42%)*
Chlamydia/gonorrhea (CT/GC) test required	22 (24%)	11 (20%)	11 (31%)
Patient needs more time to decide	17 (19%)	10 (18%)	7 (21%)
Must wait for CT/GC test results	17 (19%)	8 (14%)	9 (26%)*
Clinic flow/scheduling issues	16 (18%)	13 (24%)	3 (9%)
Patients' visit is for primary care	14 (16%)	11 (21%)	3 (9%)
Clinician(s) who perform the procedure not available	12 (13%)	10 (18%)	2 (6%)
Pap test required	9 (11%)	1 (2%)	8 (25%)*
Must wait for Pap test results	8 (9%)	1 (2%)	7 (21%)*
Patient required to be on her menses	3 (4%)	0 (0%)	3 (9%)
Billing issues	3 (3%)	2 (4%)	1 (3%)
Insufficient equipment (aside from devices) available	3 (3%)	1 (2%)	2 (6%)
Insufficient devices available onsite	2 (2%)	0 (0%)	2 (6%)
Staff are not trained to counsel	1 (1%)	1 (2%)	0 (0%)
Staff not available to counsel or to set up	1 (1%)	1 (2%)	0 (0%)

*p<.05

interested in offering contraception, “[The administration is] very concerned about our productivity because that’s the way we make money. We have to see a lot of patients . . . for us to meet our numbers.”

The absence of clinic-wide protocols on IUD placements was another sign of the lack of priority given to contraception, leaving many providers on their own to implement best practices or to rely on more experienced providers for advice. As one women’s health provider said:

We don’t have formal protocols, unfortunately. The way things are shared at my clinic are a bit haphazard, and usually it’s one-on-one. A provider will come up to me and go, “Oh, God, I just tried to put an IUD in this woman. What should I do?” We don’t have a great communication system, and not much time. I could educate people, but I’m seeing 24 patients, so it’s like, “Ah!” You know, you’re just going as fast as you can.

Time-related challenges offering IUDs in CHCs. Several providers spoke of time-related pressures hampering their ability to integrate contraception as part of their usual care. The 15-to-20-minute time slots they had to see patients were perceived as insufficient to address patient's primary care concerns, discuss contraception, conduct required screening tests, and place an IUD. As described by one provider, "The rule for my patients is that they have, like, five primary care concerns for a 15-minute visit. So, it's pretty hard to add in [contraception]."

Time pressures also affected providers' ability to train others or to increase their own competency and comfort in IUD provision. The more time needed to gain experience by observing and placing IUDs was not available. "For primary care providers [the challenge] is not knowing the procedure well enough to feel comfortable with the time allowed. Like any new procedure or something you rarely do or you don't do very often, you feel insecure about, you're just going to punt that to somebody else." Another provider explained how she elected not to be trained in IUD placement because of insufficient appointment time.

In turn, the lack of clinicians trained and comfortable placing IUDs hindered IUD provision. As one said, "Only one of our nurse practitioners places IUDs—none of us have had that training or feel comfortable doing it." Providers discussed how the need to schedule patients with a qualified provider and to screen for sexually transmitted infections (STIs) made it very difficult to offer the IUD the same day requested. The need to reschedule patients with the appropriate clinician usually meant patients waiting several days or up to six weeks after the initial visit for placement.

Scheduling challenges, the need to conduct screening tests and to address patients' primary care needs, and unavailability of trained providers resulted in multiple visits for IUD placement. One provider described how it takes several visits to become familiar with patients' multiple health care needs, making it difficult to discuss contraception until the second or third visit. An IUD-trained provider explained that while she aimed for two visits [for IUD placement], it often took in three; the first visit for consultation, the second to counsel and to schedule the patient with an IUD-trained provider (herself), and the third for placement. While this provider tried to do the counseling and placement in one day, she explained how challenging this was due to inflexibly short appointment slots:

I do have to make them [patients] come back usually, because I don't have time. I'm given 15 minutes, no matter what it's for. So, if they kind of know or we've already talked about it . . . and if they feel comfortable, we'll place it [IUD]. . . . But a lot of times that can't happen, so then I have to do [the counseling] myself, and then I have to reschedule back in, which is never a good idea . . . You just hate sending them [patients] back out. If I knew I could just [schedule] them in a week later, I'd be okay. But, you know, I can't. I almost never can do that.

Providers had mixed views as to whether single or multiple visits for IUD placement are preferable. Those in favor of same-day visits felt they reduce both patient and provider burden, and prevent extended delays, and usually were those who were already doing same-day visits in their practice. Other clinicians preferred multiple visits because they allow time to screen for STIs, to counsel, for the patient to decide, and to

reduce coercion concerns. “I feel that it is important to do it [IUD placement] in two visits to make sure that the patient doesn’t feel they are being coerced into a method, so that they are sure that they are making the decision for themselves.”

Another clinician expressed concerns that her clinic offers same-day IUD placements yet multiple visits for removals. The first visit was for consultation to discuss reasons for removal and the second to have the IUD removed:

My feeling is that if you are going to place LARC [long-acting reversible contraceptive] methods same-day, that you also need to take them out the same day. . . . It feels slightly coercive to not give that option to women on the day that they [want it out]. If they’re scheduling their appointment to get their method taken out, you can counsel, you can do all the things, but if at the end of the day they’re still like, “No, I really want it out,” then I think, personally, I think that you should take it out.

Additionally, the need to handle multiple tasks within the work day, including ordering supplies and managing electronic health records, the logistics required to set up and place IUDs and the unavailability of supplies and resources further contributed to the strain felt by providers. As one provider explained, “I work in a non-profit, super-unorganized clinic and we can’t get basic stuff.” Another provider recalled, “I don’t think we have all the equipment because one time we had to remove an IUD, they said we don’t have an IUD hook.”

Provision of the IUD as EC in CHCs is particularly challenging. Overwhelmingly the clinicians interviewed held very positive attitudes about the IUD as EC as a “safe, reliable, great long-term method” and “the best option out there.” While few had ever recommended the IUD as EC to their patients, most expressed willingness, with proper training, to recommend it in the future and said they would like to see it provided more often in their practice. “I would like to see more [IUD as EC]. Yes, I think it would be great. It is an opportune time to get someone on a LARC. It could prevent further trips to the clinic. It is the most effective EC there is so there are a lot of plusses for that.” Most clinicians agreed that potential patients know little about the IUD as EC option, and thus, providing counseling concerning this option requires more time. Only one clinician reported ever having had a patient come in requesting the IUD as EC.

The appointment time needed to place an IUD when compared with prescribing EC pills, as well as the need to bring a patient in for a visit, was viewed by several clinicians as limiting IUD as EC provision and affecting counseling practices concerning EC. One clinician explained how she doesn’t offer the IUD as EC to her patients “because I don’t think we have the capacity to provide it within the timeframe needed. I think it’s a great option.” Another described how she only discusses this option with her patients if an appointment is available. “Usually [I’ll discuss IUD as EC] in the context of when they’re calling and when an appointment is available. . . . At this point . . . it just seems hard to offer [IUD as EC] and then realize that we don’t have the capacity to support them.” Similarly another clinician explained:

The thing is that [patients] call and say that, you know, they had unsafe sex and they need a method, so I don’t have the time to go over all of my inboxes. So, I would probably see that message at the end of my day or maybe the day after. So, by that

time, I would just, you know, prescribe and send a message back to the patient saying, your prescription is ready. Go get your Plan B [EC pills].

Another provider described how the pressure to see more patients and attend to their primary care needs limited her ability to offer the IUD as EC:

I'll be straight up honest. It's a challenge of productivity. Right? It's much easier to give an EC prescription than it is to turn the visit into an IUD insert, right? And productivity being 24 patients a day in community care. I'm just really putting it out there. You know? Are you really going to push for the IUD insert as an EC when you have four other medically complicated patients who are now an hour behind already?

In contrast, despite lack of administrative support one of the few clinicians with experience providing the IUD as EC described how she prioritizes this option for patients in a "higher-risk window" similarly as one would prioritize any urgent primary care health care need:

[E]ven if it means that some other people have to wait a little bit, because it's a more pressing health need. It's like if someone had an asthma exacerbation; you would do what you needed to do that day to address their health needs. And similarly, you know, someone who's mid-cycle and has been having a lot of unprotected sex and really doesn't want to be pregnant, I think the provision of the IUD as EC is really important.

The additional steps needed for IUD as EC provision barred most clinicians from contemplating this option for their patients. One clinician listed all the things she needs to think about before offering IUD as EC to a patient: "God, I have to set up for that, or 'Where's the ParaGard [copper IUD]?' or, 'We've run out,' or whatever, you know. And I'm thinking, 'Okay, wait, am I in the right time zone? Can I do this? Is this all right?'" Another clinician described succinctly how "it takes so much setup . . . and, the stars aligning for an impromptu IUD to happen."

One clinician expressed that she would not recommend the IUD as EC to patients because patients need more time with the clinician:

I feel like there is a lot going on with the process on feeling they may be pregnant, I want more hands on time with them to work with them, I feel that the IUD as EC is safe, effective, but I would want them to come back for an additional visit, so that I could talk about how did we get into this situation, and I want them to come back. I wouldn't do the [IUD as EC] the same day of the visit. I may feel differently five years from now.

Reducing barriers to providing IUDs in CHCs. Providers listed a number of ways in which provision of IUDs could be improved in their practices. These included integrating contraceptive counseling within routine primary care visits, training clinicians and staff on IUD placement, better integrating support staff, and ensuring availability of devices and supplies. Some clinicians pointed to how support staff, such as medical assistants

(MAs), nurses, triage staff, and health educators, could conduct initial contraceptive screening, provide health education and basic contraceptive counseling, and assist with the set-up for the procedure. This they felt would help to increase patients' knowledge and comfort with IUDs and reduce overall time for IUD placement, thereby enabling clinicians to serve their patients within the short time slots available and meet expectations to serve a high volume of patients.

Nearly all interviewees mentioned that more training of both clinicians and staff was needed in order to increase accessibility of IUDs. Allotting time for on-going continuing education and hands-on training for providers, including on-site proctoring, was cited as a key to offering IUDs more regularly. One clinician expressed the need to have supervision, practice, and repetition in order to be able to place IUDs. Some interviewees noted that the clinic as a whole would need protected time to discuss information and strategies for provision among clinic staff and providers. Finally, one clinician put the burden on herself to increase access to IUD as EC. "I think if I have the training, I will do it. Yeah, I think . . . the medical director is going to support it, yes, and I feel comfortable doing it. . . . Well, once I—once I start presenting that as the preferred—the most effective preferred way of contraception, then I'm interested to see some changes on the patient's acceptance level."

Clinicians from practices where streamlined IUD provision was commonplace listed the factors that facilitated same-day placements. These included having trained providers, supplies on hand, flexible or open schedules, and additional support from health educators, medical assistants and/or other support staff.

Discussion

The importance of screening women for contraceptive needs at any given primary care encounter has been highlighted as an important component of quality reproductive health services.^{20,21} Yet, despite increased availability and favorable provider attitudes towards the IUD, most CHC providers reported challenges prioritizing contraception over other pressing primary care needs, felt distressed for their patients by not being able to do so, and were unable to offer the IUD as an EC or same-day option. We learned from CHC providers the need to gain administrative support to better integrate staff as part of their support structure, and to provide clinicians with the time to train and be trained, in order to facilitate contraceptive service provision. These systems-level challenges identified by this and other studies²² indicate a need to shift the incentive structure so that CHCs can support the provision of quality reproductive health care.

Consistent with other studies, same-day IUD provision was infrequent.^{9,14} While STI screening is not always required,²³ and same-day IUD provision is considered best practice for interested patients as long as pregnancy can be reasonably excluded, many providers felt streamlined care was not possible. The need to schedule patients with a trained provider, and to counsel, screen, and allow patients enough time to make an autonomous decision prevented same-day provision in many practices.

Similarly, few providers offered the IUD as EC to their patients. The additional requirements to place an IUD when compared with prescribing ECPs—an office visit with an IUD-trained clinician, the stocking of a costly device, time to discuss a patient's

preferences, to inform them about their options, and to rule out contraindications—felt insurmountable for most clinicians. Those who wanted to offer this option often did not because they felt their practice did not have the capacity to so. The few providers who offered the IUD as EC to patients tailored their counseling depending on whether they felt it was a viable option at their clinic that day. One provider expressed the importance of treating the EC visit just as one would treat other emergency primary care needs, as a way of overcoming barriers to provision.

For practices that already offer the IUD, offering the IUD as EC as part of their routine EC counseling would better ensure that women have more contraceptive options, and are better able to prevent an unwanted pregnancy after unprotected sex. This is particularly important since women report interest in using the IUD as EC and because it is more effective at preventing pregnancy than ECs.^{24,25} In contexts where barriers to IUD as EC provision have been removed and women are offered a choice in EC methods, as many as 40% choose the IUD as EC.^{26,27}

Providers voiced concerns that streamlined IUD provision could result in rash decision-making, pressure to use a method, and failure when multiple visits are offered for removals. These concerns are important when we consider the history of reproductive coercion²⁸ and the potential for a general over-enthusiasm towards IUDs to threaten women's reproductive autonomy.^{29–31} Yet, while multiple visits may accrue important benefits to women, they often result in rescheduling women several weeks later, potentially denying them their desired method. One study of women requesting an IUD at an urban university found that only about half returned for the insertion visit.³² Thus, while streamlining visit protocols may be optimal to ensure that women receive the method they desire, it is also important to ensure that women are given enough time and information to make their own informed decision, and that their desire for removals be equally supported. It is important to consider that single-visit protocols may be preferred by some but not necessarily all women.

This study was limited to a small sample of CHCs concentrated in one geographical location, all offering IUDs onsite at no cost to eligible patients, thus results may not be generalizable to other contexts. Practices where IUDs are not available, and the cost to patients is high, likely face additional challenges to contraceptive provision. Another limitation of this study is that many of the providers interviewed had recently participated in one of our educational seminars and/or hands-on IUD placement trainings. Therefore their awareness about the IUD as EC was likely higher; the challenges to streamlined IUD provision are likely greater in other contexts.

This study sheds some light into the challenges CHCs face in providing women a full range of contraceptive options. When we consider the additional demands placed on CHC providers over family planning providers—seeing a high volume of patients and addressing their primary care needs—improving access to IUDs will require removing systemic challenges in order for IUDs to become a more viable option for women. The lack of administrative support, trained providers, as well as the lack of streamlined and coordinated services, must be addressed in order to increase access to the IUDs in CHC locations. Efforts to increase women's access to IUDs must also be carried out cautiously, always protecting women's reproductive autonomy.

Declaration of Interests

All authors declare they have no financial or personal conflicts of interest.

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